CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH
DRUG CONTROL & PROFESSIONAL PRACTICES BRANCH
275 EAST MAIN STREET
FRANKFORT 40621-0001

For Office Use Only
Lic. No._____
Date Rec._____

LICENSE UPDATE
MANUFACTURER OR WHOLESALER
OF CONTROLLED SUBSTANCES

Please fill out item 1. Then complete only those items for which changes are being submitted.

1. Name of Licensee: _____

Kentucky Controlled Substance License number: _____

Telephone: _____ Fax: _____

2. Schedule(s) □ II □ IIN □ III □ IIIN □ IV □ V (Check all that apply)

3. □ 1,4 Butanediol, Gamma-Butyrolactone, GBL, Dihydro-2(3H)-furanone, 1,2-Butanolide, 1,4-Butanolide; 4-Hydroxybutanoic acid lactone, gamma-hydroxybutyric acid lactone (Code of Federal Regulations 21 Part 1310.02 (a)) – Industrial Use Only – Not for human consumption

4. All trade or business names:

5. Contact person(s) for the handling, storage or recordkeeping of controlled substances (attach additional pages if necessary):

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
Telephone	Telephone

6. Type of ownership:

□ Individual/Sole Proprietorship

_____
Name

_____
Address

□ Partnership: (Attach additional pages if necessary)

_____
Name of Partnership

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Name of Partner _____ Name of Partner _____

Address of Partner _____ Address of Partner _____

☐ Limited Liability Company: (Attach additional pages if necessary)

Name of LLC _____

Name of Manager or Member _____ Name of Manager or Member _____

Address of Manager or Member _____ Address of Manager or Member _____

☐ Corporation

Name of Corporation _____

State of Incorporation _____

Name and title of each corporate officer and director: (Attach additional pages if necessary)

Name _____ Name _____

Title _____ Title _____

Name _____ Name _____

Title _____ Title _____

Name _____ Name _____

Title _____ Title _____

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7. Describe the business, the physical facilities, and the type security provided. (Attach additional pages if necessary)

8. DEA number of licensee: _____ Expiration date_____

9. Has applicant or any partner, officer, director or agent ever been convicted of a misdemeanor involving any controlled substance?
☐ Yes (attach explanation) ☐ No

10. Has any applicant or any partner, officer, director, or agent been convicted of any felony?
☐ Yes (attach explanation) ☐ No

I understand that the Cabinet for Health Services shall be notified in the event of any theft or other loss of controlled substances. Any problem, such as pilferage, which develops in a facility, must also be reported. Assistance may be available if desired.

I hereby certify that all answers given in this application are true, complete and correct and I understand that any license issued to me by the Cabinet for Health Services may be suspended or revoked for cause.

_____

Printed Name & Title of Respondent

_____ _____

Signature Date